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CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)
SPECIAL TERMS AND CONDITIONS (STCs)
HEALTH INSURANCE FLEXIBILITY AND ACCOUNTABILITY (HIFA)
SECTION 1115 DEMONSTRATION PROJECT

NUMBER: 11-W-00146/6 (Title XIX Medicaid funding)
21-W-00012/6 (Title XXI—SCHIP funding)

TITLE: New Mexico State Coverage Initiative (New Mexico SCI)

AWARDEE: State of New Mexico Department of Human Services

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I. PREFACE

The following are Special Terms and Conditions (STCs) for the New Mexico's Health Insurance Flexibility and Accountability section 1115 demonstration program, entitled State Coverage Initiative (SCI). The Special Terms and Conditions have been arranged into the following subject areas: General Program Conditions, General Reporting Requirements, Legislation, Eligibility and Enrollment, Benefits, Cost Sharing, Program Design, Operational Protocol, Title XIX Financial Requirements, and Title XXI Financial Requirements.

Amendment requests, correspondence, documents, reports, and other materials that are submitted for review or approval shall be directed to the Centers for Medicare & Medicaid Services (CMS) Central Office Project Officer and the Regional Office State Representative at the addresses shown on the award letter.

The state agrees that it will comply with all applicable Federal statutes relating to nondiscrimination. These include, but are not limited to: the Americans with Disabilities Act, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

II. GENERAL PROGRAM CONDITIONS

1. **Pre-Implementation Requirements.** All STCs prefaced with an asterisk (*) contain requirements that must be approved by CMS prior to the implementation date for the demonstration. No Federal financial participation (FFP) will be provided for section 1115 program demonstration eligibles until CMS has approved these requirements. The FFP will be available for project development and implementation, compliance with STCs, the readiness review, etc. Unless otherwise specified where the state is required to obtain CMS approval of a submission, CMS will make every effort to respond to the submission in writing within 45 days of receipt of the submission. The CMS and the State will make every effort to ensure that each submission is approved within 60 days from the date of CMS's receipt of the original submission.

2. **Definitions.** For purposes of the STCs, the following definitions apply.

    a) The "Implementation date" is defined as the first date on which coverage to demonstration eligibles is available. The FFP for the New Mexico State Coverage Initiative (SCI) is not available until the implementation date. The CMS must approve in writing the state's proposed implementation date.

    b) The SCI demonstration eligibles are defined as follows:

    c) **Demonstration Population 1**: Uninsured parents of Medicaid and SCHIP eligible children, who are not otherwise eligible for Medicaid or Medicare, with net income ranging up to and including 200 percent of the Federal poverty level (FPL).

Demonstration Population 2: Uninsured adults without dependent children ages 19-64 with incomes through 200 percent of the Federal Poverty Level (FPL) who are not otherwise eligible for Medicaid or Medicare.

3. **Adequacy of Infrastructure.** The demonstration includes adequate resources for the implementation and monitoring of the SCI demonstration, including education, outreach and enrollment, maintaining eligibility systems; compliance with cost-sharing limits; and reporting on financial and other issues.

4. ***Public Notice and Consultation.** As demonstrated by previous documentation, the State will continue to comply with the public notice requirements issued via September 27, 1994 edition of the *Federal Register*, and the tribal consultation requirements issued via letter by CMS on July 17, 2001. In the event the State conducts additional consultation activities consistent with these requirements prior to the implementation, documentation of these activities will be provided to CMS.

5. ***Preparation of Operational Protocol.** Prior to service delivery under this demonstration, the State must prepare and CMS must approve an Operational Protocol document that represents all policies and operating procedures applicable to this demonstration. The required content of the Operational Protocol is outlined in section IX of these STCs.

6. **Extension or Phase-out Plan.** No later than 12 months prior to the expiration of the demonstration, the State must notify CMS whether it plans to request an extension of the demonstration. Requests for extensions will be due no later than 1 year prior to the expiration of the demonstration. If the State does not intend to request an extension, it must submit to CMS a phase-out plan no later than 1 year prior to the expiration of the demonstration. The phase-out plan is subject to CMS review and approval.

7. **Enrollment Limitation During the Last 6 Months.** If the demonstration has not been extended, no new enrollment is permitted during the last 6 months of the demonstration.

8. **Cooperation with Federal Evaluators.** The State must fully cooperate with Federal evaluators and their contractors' efforts to conduct a federal evaluation of the demonstration program.

9. **CMS Right to Terminate or Suspend.** The CMS may suspend or terminate this project in whole or in part at any time before the date of expiration, whenever it determines that the State has materially failed to comply with the terms of the project. The CMS will promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date. The State waives none of its rights under 42 CFR 430, Grants to States for Medical Assistance Programs, to challenge CMS's finding that the State materially failed to comply. The CMS reserves the right to deny pending waiver requests or withdraw waivers at any time if it determines that granting or continuing the waivers would no longer be in the public interest. Subsequent to the release of this approval letter and terms and conditions, CMS does not anticipate changes to the New Mexico State Medicaid Plan, in terms of reduced coverage groups or reduced benefits, as a means of

providing savings to cover individuals under the demonstration. Such changes could affect the continuation of the demonstration. If the project is terminated or any relevant waivers withdrawn, CMS will be liable for only normal close-out costs.

10. **State Right to Terminate or Suspend.** The State may suspend or terminate this demonstration in whole or in part at any time before the date of expiration. The State must promptly notify CMS in writing of the reasons for the suspension or termination, together with the effective date. If the project is terminated or any relevant waivers suspended by the State, CMS will be liable for only normal close-out costs.

III. GENERAL REPORTING REQUIREMENTS

1. **Quarterly Progress Reports.** No later than 60 days after the end of each quarter, the State must submit progress reports. These reports must include information on operational and policy issues appropriate to the State's program design. The report must also include information on any issues that arise in conjunction with the demonstration. This information may include but not be limited to the: 1) monitoring the substitution of public coverage, 2) monitoring aggregate costs for enrollees in the premium assistance program, and 3) summarizing the numbers and types of grievances and resolved appeals. The report's final format will be determined by CMS and the State. The report must also include proposals for addressing any problems identified in each report. The State will also include a separate section to report on progress toward agreed-upon goals for reducing the rate of uninsurance. From data that are readily available, the State will monitor the private insurance market (e.g., changes in employer contribution levels, if possible, among employers with low-income populations), trends in sources of insurance, etc. and other related information in order to provide a context for interpreting progress toward reducing uninsurance. The State will also continue to monitor substitution of coverage (i.e., participants dropping private coverage). The State must include a discussion of the specific content of these reports in the Operational Protocol (see Section IX).

2. **Quarterly Enrollment Reports.** The State will provide CMS with an actual and unduplicated enrollment report for the demonstration populations.

3. **Monitoring Calls**. The CMS and the State will hold monthly monitoring calls to discuss issues associated with the implementation and operation of the demonstration.

4. **Annual Reports.** The State must submit a draft annual report documenting accomplishments, including project status, budget update; quantitative and any case study findings; policy and administrative difficulties; and progress on conducting the demonstration evaluation, including results of data collection and analysis of data to test the research hypotheses no later than 6 months after the end of its operational year. The annual report must also include: 1) State tracking the rate of uninsured; and 2) documenting any changes in the insured rates for the insurance coverage categories (i.e., employees enrolled in SCI by income level) and population groups (i.e. dependent spouse, unemployed, self-employed). Within 30 days of receipt of comments from CMS,

a final annual report will be submitted. The State must include a discussion of the specific content of these reports in Operational Protocol (see Section IX). In addition, the report should address the areas to be evaluated as described in Section IX.13 and those to be monitored as described in Section X.

5. **Final Report.** At the end of the demonstration, a draft final report must be submitted to CMS for comments. The CMS's comments shall be taken into consideration by the State for incorporation into the final report. The CMS's document *Author's Guidelines: Grants and Contracts Final Reports* is available to the State upon request. The final report is due no later than 90 days after the termination of the project.

IV. LEGISLATION

1. **Changes in the Enforcement of Laws, Regulations, and Policy Statements.** All requirements of the Medicaid/SCHIP program expressed in laws, regulations, and policy statements, not expressly waived or identified as not applicable in the award letter of which these STCs are part, will apply to the demonstration. To the extent that changes in the enforcement of such laws, regulations, and policy statements would have affected State spending in the absence of the demonstration in ways not explicitly anticipated in this agreement, CMS (after consultation with the State) will incorporate such effects into a modified budget limit for the demonstration. The modified budget limit would be effective upon enforcement of the law, regulation, or policy statement. If the law, regulation, or policy statement cannot be linked specifically with program elements of the HIFA demonstration (e.g., all disallowances involving provider taxes or donations), the effect of enforcement on the State's budget limit will be proportional to the size of the demonstration in comparison to the State's entire Medicaid program (as measured in aggregate medical assistance payments).

2. **Changes in Medicaid/SCHIP Law.** The State must, within the time frame specified in law, come into compliance with any changes in Federal law affecting the Medicaid/SCHIP program that occur after the demonstration award date. To the extent that a change in Federal law, which does not exempt state section 1115 demonstrations, would affect State Medicaid spending in the absence of the demonstration, CMS will incorporate such changes into a modified budget limit for the demonstration. The modified budget limit will be effective upon implementation of the change in Federal law, as specified in law. If the new law cannot be linked specifically with program elements of the HIFA demonstration (e.g., laws affecting sources of Medicaid funding), the State must submit its methodology to CMS for complying with the change in law. If the methodology is consistent with Federal law and in accordance with Federal projections of the budgetary effects of the new law, CMS would approve the methodology. Should CMS and the State, working in good faith to ensure State flexibility, fail to develop within 90 days a methodology to revise the without waiver baseline that is consistent with Federal law and in accordance with Federal budgetary projections, a reduction in Federal payments will be made according to the method applied in non-demonstration states.

V. ELIGIBILITY AND ENROLLMENT

Screening for Medicaid. Applicants for the demonstration will be screened for Medicaid eligibility. Demonstration applicants eligible for Medicaid will be enrolled in Medicaid and receive the full Medicaid benefit package. During the demonstration project, eligibility status of participants will be redetermined on a 12-month period.

VI. BENEFITS

The CMS is approving the SCI benefit package outlined in Attachment C of the State's HIFA proposal. If changes are made in the benefit package, the State must submit a change to the operational protocol document, which must be reviewed and approved before implementation of change.

VII. COST SHARING

Cost-sharing amounts are approved as specified in Attachment E of the HIFA proposal, and out-of-pocket costs will be limited to an annual aggregate amount of 5 percent of family income. Any requested changes to the cost-sharing amounts will be submitted as a revision to the operational protocol document and be subject to review and approval. If an individual reaches the out-of-pocket maximum and is not required to pay the monthly premium or copayments at any time, the additional costs due to the absence of the premium sharing or copayment will be paid by the State to the **MCOs** including associated FFP at the corresponding title XXI or title XIX rate.

VIII. PROGRAM DESIGN

1. **Concurrent Operation.** The State's title XXI state plan, as approved, will continue to operate concurrently with this section 1115 demonstration.

2. **Maintenance of Coverage and Enrollment Standards for Children**

   a) The State shall not close enrollment, institute waiting lists, or decrease eligibility standards with respect to the children covered under its title XXI state plan while the demonstration is in effect.

   b) The State shall, throughout the course of the demonstration, continue to show that it has implemented procedures to enroll and retain eligible children for Medicaid and SCHIP.

   c) The State will establish a monitoring process to ensure that expenditures for the HIFA amendment do not exceed available title XXI funding (i.e., the title XXI allotment or reallocated funds) and the appropriate state match. The State will use title XXI funds to cover services for the SCHIP and HIFA populations in the following priority order:

- Children eligible under the title XXI State plan.
- Demonstration Populations 1 and 2.

If the State determines that title XXI funding will be exhausted, available title XXI funding will first be used to cover costs associated with the title XXI state plan population. The State will not close enrollment, institute waiting lists, or decrease eligibility standards with respect to the children covered under its title XXI State plan while this demonstration is in effect.

The state may also, for the demonstration populations:

- Lower the federal poverty level used to determine eligibility, and/or
- Suspend eligibility determination and/or intake into the program, or
- Discontinue coverage

Before taking any of the above actions related to the priority system, New Mexico will provide 60-day notice to CMS.

IX. OPERATIONAL PROTOCOL

1. ***Prior Approval.** Prior to service delivery under the demonstration, the State must prepare, and CMS must approve, a single Operational Protocol document representing all policies and operating procedures of the demonstration. The protocol must be submitted to CMS no later than 90 days prior to program implementation. CMS will respond within 60 days of receipt of the protocol regarding any issues or areas that require clarification. No Federal Financial Participation (FFP) will be provided for Medical Assistance Payments under the HIFA demonstration project until CMS has approved the Operational Protocol. FFP will be available for project development and implementation, and compliance with Special Terms and Conditions. The State must assure and monitor compliance with the protocol.

2. **Changes to the Operational Protocol.** During the demonstration, subsequent changes to demonstration program and the Operational Protocol that are the result of major changes in policy or operating procedures must be submitted for review by CMS. The State must submit a request to CMS for these changes no later than 90 days prior to the date of implementation of the change (s).

3. **Operational Protocol Content.** At a minimum, the protocol must address all of the following areas, plus any additional features of the demonstration referenced in these Special Terms and Conditions or the State's application for a HIFA demonstration.

    a) **Organization and Structural Administration.** A description of the organizational and structural administration that will be in place to implement, monitor, and operate the demonstration, and the tasks each organizational component will perform. Include details about eligibility, outreach, enrollment (including those who are unemployed or with no access to employer sponsored insurance), coordination with

private health insurance coverage, enrollment/disenrollment process into the MCOs, compliance with cost sharing limitations, accountability and monitoring, and financial management.

b) **Reporting Items.** A description of the content and frequency of each of reporting items as listed in Section III of this document

c) **Income Limit.** A detailed discussion of the income limits the State will use for the program.

d) **Eligibility/Enrollment.** A detailed description of all groups eligible for the demonstration and a description of the processes for eligibility determination and annual redetermination, enrollment and disenrollment, and procedures for ensuring that all applicants will be screened for and placed in the most beneficial programs for their needs as described in Section V.1. Also describe the State's outreach, marketing, and staff training strategy, including: information that will be communicated to providers, potential demonstration participants, and State outreach/education/eligibility staff; types of media to be used; specific geographical areas to be targeted; types of locations where such information will be disseminated; and the availability of bilingual materials/interpretation services and services for individuals with special needs. The State should also describe how it will review and approve marketing materials prior to their use.

e) **Implementation Schedule.** Please discuss the operational details and provide an implementation schedule.

f) **Quality.** Describe the State's overall quality assurance monitoring plan. The plan should include, at a minimum, the following: Quality indicators to be employed to monitor service delivery under the demonstration and the system to be put in place so that feedback from quality monitoring will be incorporated into the program; quality monitoring surveys, and the monitoring and corrective action plans to be triggered by the surveys; and fraud control provisions and monitoring.

g) **Grievances and Appeals.** Provide a description of the grievance and appeal policies that will be in place in the demonstration and how the process will be monitored.

h) **Title XXI Financing.** A description of the process for monitoring allotment neutrality, and the procedures for meeting the financial requirements specified in Attachment B. The description should include the State's process for ensuring that care is not interrupted for the approved State plan population and that enrollment and expenditure caps are not exceeded for the demonstration populations should the State expend the full amount of the available Federal funds during the demonstration period.

i) **Uninsured Rates.** The Operational Protocol must include the State's monitoring plan to track changes in the uninsured rate and trends in sources of insurance, including

submission of progress reports discussed in Section III. Include in the description of the plan information on the sources of data and adjustments that were made to establish the base line and which will need to be made in the future. The State should plan on monitoring whether there are unintended consequences of the demonstration such as high levels of substitution of private coverage and major decreases in employer contribution levels. This section should discuss the State's plans to measure and report on the following: Changes in the uninsured rate for the population groups listed above; changes in the insured rates for the insurance coverage categories and population groups listed above; the degree of substitution of public coverage for employer coverage; the lengths of time enrollees have been uninsured prior to enrolling in the demonstration; the extent to which employers reduce their contributions for employer sponsored insurance; the extent to which employers discontinue employer sponsored insurance for their employees, and the extent to which individuals appear to be dropping employer coverage in order to enroll in the demonstration.

j) **Evaluation Design.** Provide a more detailed description of the State's evaluation design included in its approved HIFA proposal, including:

- a discussion of the demonstration hypotheses that will be tested;
- outcome measures that will be included to evaluate the impact of the demonstration;
- what data will be utilized;
- the methods of data collection;
- how the demonstration affects the employer market and the extent to which individuals who lack access to ESI participation are enrolled.
- how the effects of the demonstration will be isolated from those other initiatives occurring in the State; and
- any other information pertinent to the State's evaluative or formative research via the demonstration operations.

X. MONITORING

1. The State must monitor changes in employer contribution levels or the degree of substitution of coverage and be prepared to make changes to its premium assistance program in response to substantial decreases in contribution levels or data showing significant substitution of coverage.

2. The impact of the demonstration on the group market with respect to health insurance issuer's participation requirements for employers.

ATTACHMENT A

GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

Note: This Attachment and any reference in these Special Terms and Conditions to Budget Neutrality under Title XIX will become effective upon CMS and the State negotiating a Budget Neutrality agreement including per-member per-month costs and trend rates, in accordance with Attachment B.7.

1. The State will provide quarterly expenditure reports using the Form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. The CMS will provide Federal Financial Participation (FFP) for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits that are established in accordance with Attachment B, item #7.

2. **a.** In order to track expenditures under this demonstration, the State will report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 of the State Medicaid Manual. All expenditures subject to the budget neutrality cap will be reported on separate Forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). For monitoring purposes, cost settlements must be recorded on Line 10.b, in lieu of Lines 9 or 10c. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10.c, as instructed in the State Medicaid manual. The term, "expenditures subject to the budget neutrality cap," is defined below in item 2.b.

b. For the purpose of this section, the term "expenditures subject to the budget neutrality cap" will include all Medicaid expenditures on behalf of Demonstration Population 1 participants as defined in Section II.2b of these Special Terms and Conditions.

c. At such time the State determines that it does not have sufficient Title XXI funds to cover expenditures for Demonstration Population 1 and begins claiming Title XIX funds for this population, the State will complete for each demonstration year a Form CMS-64.9WAIVER and/or 64.9P WAIVER reporting expenditures subject to the budget neutrality cap. All expenditures subject to the budget neutrality ceiling for demonstration eligibles must be reported. The sum of the expenditures, for all demonstration years reported during the quarter, will represent the expenditures subject to the budget neutrality cap (as defined in 2.b.).

d. Administrative costs will not be included in the budget neutrality limit, but the State must

separately track and report additional administrative costs that are directly attributable to the demonstration.

e. All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the 1115 demonstration on the Form CMS-64 in order to properly account for these expenditures in determining budget neutrality.

f. The procedures related to this reporting process, report contents, and frequency must be discussed by the State in the Operational Protocol (see Section VIII.)

3. a. For the purpose of calculating the budget neutrality expenditure cap referenced in Attachment B.7, the State must provide to CMS on a quarterly basis the actual number of eligible member/months for the demonstration eligibles as defined below. These will include only member months for Demonstration Population 1 whose expenditures are matched at the regular FMAP rate. This information should be provided to CMS in conjunction with the quarterly progress report referred to in number 1 of Section III. If a quarter overlaps the end of one demonstration year (DY) and the beginning of another, member/months pertaining to the first DY must be distinguished from those pertaining to the second. (Demonstration years are defined as the years beginning on the first day of the demonstration, or the anniversary of that day.) Procedures for reporting eligible member/months must be defined in the Operational Protocol (see Section IX).

b. The term, "eligible member/months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes three eligible member/months to the total. Two individuals who are eligible for 2 months each contribute two eligible member months to the total, for a total of four eligible member/months.

c. There will be one Medicaid eligibility group (MEG) under the demonstration. The MEG will be the parents of Medicaid and SCHIP children with incomes through 200 percent FPL (Demonstration Population 1). These are individuals who could be eligible for Medicaid under Section 1931 if the State further liberalized its eligibility criteria in the State Plan.

4. The standard Medicaid funding process will be used during the demonstration. New Mexico must continue to estimate total matchable Medicaid expenditures for the entire program on the quarterly Form CMS-37. In addition, the estimate of matchable demonstration expenditures (total computable/federal share) subject to the budget neutrality cap must be separately reported by quarter for each federal fiscal year on the Form CMS-37.12 for both the Medical Assistance Program (MAP) and Administrative Costs (ADM). As a supplement to the Form CMS-37, the State will provide updated estimates of expenditures subject to the budget

neutrality cap as defined in 2 c. of this Attachment. CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS will reconcile expenditures reported on the Form CMS-64 annually with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

5. CMS will provide Federal Financial Participation (FFP) at the applicable Federal matching rate for the following, subject to the limits referenced in Attachment B.7:

a. Administrative costs, including those associated with the administration of the demonstration.
b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved State Plan.
c. Net medical assistance expenditures made under Section 1115 demonstration authority, including those made in conjunction with the demonstration.

6. The State will certify State/local monies used as matching funds for the SCI demonstration and will further certify that such funds will not be used as matching funds for any other federal grant or contract, except as permitted by federal law.

ATTACHMENT B

GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XXI

1. The State shall provide quarterly expenditure reports using the Form CMS-21 to report total expenditures for services provided under the approved SCHIP plan and those provided through the New Mexico Demonstration under section 1115 waiver authority. This project is approved for expenditures applicable to services rendered during the demonstration period. The CMS will provide Federal Financial Participation (FFP) only for allowable New Mexico Demonstration expenditures that do not exceed the State's available Title XXI funding.

2. In order to track Title XXI expenditures under this demonstration, the State will report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-21 reporting instructions outlined in Section 2115 of the State Medicaid Manual. Title XXI demonstration expenditures will be reported on separate Forms CMS-21 Waiver and/or CMS-21P Waiver, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). A separate Form CMS-21 Waiver and/or CMS-21P Waiver must be completed for Demonstration Population 1 and for Demonstration Population 2.

   a) All claims for expenditures related to the demonstration (including any cost settlements) must be made within two years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the demonstration period (including cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the Form CMS-21.

   b) The standard SCHIP funding process will be used during the demonstration. New Mexico must estimate matchable SCHIP expenditures on the quarterly Form CMS-21B. As a footnote to the CMS-21B, the State shall provide updated estimates of expenditures for the demonstration populations. CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-21 quarterly SCHIP expenditure report. CMS will reconcile expenditures reported on the Form CMS-21 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

   c) The State will certify State/local monies used as matching funds for the demonstration and will further certify that such funds will not be used as matching funds for any other federal grant or contract, except as permitted by federal law.

3. New Mexico will be subject to a limit on the amount of Federal Title XXI funding that the State may receive on demonstration expenditures during the waiver period. Federal Title XXI funding available for demonstration expenditures is limited to the State's available allotment, including currently available reallocated funds. Should the State expend its available Title XXI Federal funds for the claiming period, no further enhanced Federal matching funds will be available for costs of the approved Title XXI child health program or demonstration until the next allotment becomes available.

4. Total Federal Title XXI funds for the State's SCHIP program (i.e., the approved title XXI State plan and this demonstration) are restricted to the State's available allotment and reallocated funds. Title XXI funds (i.e., the allotment or reallocated funds) must first be used to fully fund costs associated with the State plan population. Demonstration expenditures are limited to remaining funds.

5. Total expenditures for outreach and other reasonable costs to administer the Title XXI State plan and the demonstration that are applied against the State's Title XXI allotment may not exceed ten percent of total Title XXI expenditures.

6. If the State exhausts the available Title XXI Federal funds in a Federal fiscal year during the period of the demonstration, the State may continue to provide coverage to the approved Title XXI State plan child health program population and Demonstration Populations 1 and 2 with State funds only. However, the State can elect to draw down title XIX funds for the title XXI State Plan population.

7. If Title XXI allocations are expended and New Mexico chooses to draw down regular Title XIX matching funds for Demonstration Population 1 under section 1115 waiver authority, a Section 1115 budget neutrality agreement, including per-member per-month costs and trend rate, must be established for this Demonstration Population in consultation with New Mexico. CMS will consider New Mexico's Title XXI expenditure experience in establishing the cap. In order to provide for a seamless continuation of 1115 waiver authority for this population under Title XIX, New Mexico should provide CMS with adequate notification if the State's projections indicate that it may exceed its Title XXI allocation. With respect to Demonstration Population 2, the State has not requested authority to use Title XIX funding. If in the future the State wishes to receive Title XIX funding for this population, CMS and the State would need to negotiate a budget neutrality agreement which includes a source of Medicaid savings to offset the additional cost of this population to Title XIX.

All Federal rules shall continue to apply during the period of the demonstration that Title XXI Federal funds are not available. The State is not precluded from closing enrollment or instituting a waiting list with respect to the Demonstration Populations. Before closing enrollment or instituting a waiting list, the State will provide 60-day notice to CMS.